MARYLAND STATE DEPARTMENT OF HEALTH

REPORT

OF A

HEALTH OFFICER COMMITTEE ON THE COORDINATION

OF PREVENTIVE AND CURATIVE SERVICES

MAY 7, 1948

Maryland State Department of Health

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MEMBERSHIP OF COMMITTEE

WILLIAM H. F. WARTHEN, M.D., Deputy State Health Officer of Baltimore County, Chairman

P. F. PRATHER, M.D., Deputy State Health Officer of Washington County

W. B. JOHNSON, M.D., Deputy State Health Officer of Dorchester County

WILLIAM A. HARRIS, M.D., Deputy State Health Officer of Charles County

DEAN ROBERTS, M.D., Chief, Bureau of Medical Services, Maryland State Department of Health

W. ROSS CAMERON, M.D., Chief, Division of Cancer Control, Maryland State Department of Health

C O N T E N T S

CHARGE
TO
THE COMMITTEE ON THE COORDINATION OF
PREVENTIVE AND CURATIVE SERVICES

The committee is charged with the following responsibilities:

1. Study existing records of services rendered under the medical services program in several representative counties. (Form MS-8).
2. Take other steps to determine the extent to which preventive services are provided by the county health departments for beneficiaries of the program.
3. Suggest possible arrangements between the county health departments and private practitioners that might be expected to promote closer coordination between preventive and curative services.
4. Detail the preventive and curative services that might be provided routinely by:
    a. State and county health departments
    b. Private physicians
    c. Other agencies

    Under this topic, such questions as these should be discussed:
    a. Should a complete physical examination be provided for all persons being certified for medical care at public expense?
    b. If such an examination could be made routinely, what steps might be taken to secure correction of defects?
    c. Are the county health departments equipped to make periodic physical examinations?
    d. What expense would be involved in providing such facilities?
    e. Are funds for this purpose procurable?
5. Study the current record system and decide whether it would be wise to develop in each county health department a central index file for coordinating records of preventive and curative services.

6. Consider other procedures that might be developed to promote closer coordination.

7. Propose plans for more complete utilization of the vocational rehabilitation service and similar agencies.

8. Confer with those who might be expected to contribute to the completion of the study.

9. Submit recommendations to the Director of the State Department of Health.

May 22, 1947
Medical Care Program

A C K N O W L E D G E M E N T S

To Dr. Robert H. Riley, Director of the Maryland State Department of Health, for giving to the Committee on the Coordination of Preventive and Curative Services the opportunity for the profitable educational experience of exploring the intricacies of local preventive and curative services in the counties of Maryland; to all Deputy State Health Officers who have freely commented upon and given suggestions to the Committee in its work; to Bureau Chiefs and others in the Central Office of the Maryland State Department of Health who have advised the Committee and given generously of their time and effort in this report, the members of the Committee as a whole and individually are most appreciative and deeply grateful.

The Committee wishes to thank sincerely Miss Elizabeth McIntire, Secretary to the Chief of the Bureau of Medical Services, for her fine contribution of meticulous note-taking during the all day conference of the Committee with Deputy State and County Health Officers on January 22.

Miss Katherine Harris, Secretary to the Health Officer of Baltimore County has given hours of extra time to taking the minutes of the many Committee meetings held throughout the year and she has displayed extraordinary patience in the painstaking task of preparing the many revisions in the several stages of the development of this report. This mimeographed volume is largely Miss Harris' handiwork. The Committee is grateful for her willing and generous efforts at all times.

Miss Virginia Raphel of the Baltimore County Health Department very kindly drew the original stencil for the illustration in the APPENDIX.

Maryland State Department of Health

REPORT OF A HEALTH OFFICER COMMITTEE ON THE COORDINATION OF PREVENTIVE AND CURATIVE SERVICES

INTRODUCTION

The salient features of the program for supplying medical care to those in Maryland who would not otherwise receive it were described by Dr. Robert H. Riley in an article in the August, 1946, American Journal of Public Health.* The purposes and origins of the program as it concerns the counties of Maryland were reviewed and the techniques of administering the fee-for-service plan finally adopted were described. It was pointed out that late in 1939 following an open letter from the Medical and Chirurgical Faculty of Maryland to the State Planning Commission a standing Committee on Medical Care was appointed with instructions to make a field survey of the needs of the people of the counties of Maryland for curative and preventive medical services and to make recommendations for the improvement of any deficiencies found. The Committee outlined five major objectives of this field survey. It is the fourth of these which is of prime importance and interest to those who study the development of the integration of preventive medical and curative services as applied in the county as a unit. The fourth objective of the survey is stated as follows:

> "To study the state health needs and give suggestions for securing more effective use of existing agencies, either by improving or extending their activities or by the organization of other services."

*Riley, Robert H., Medical Care in Maryland, American Journal of Public Health, August, 1946, Vol. 36, No. 8, pp. 908-911.

It is well known by those who worked closely with the Medical Care Committee that much thought was given during its many meetings to the correctness of this original thesis: that the State Health Department and its local agents, the county health departments, should organize and operate a medical care program. As data in the survey were collected and analyses were made it became increasingly clear that the service to be rendered by a medical care program, must be closely integrated with those already in existence and should logically, therefore, be included in the health department organization rather than in another agency of the State government. The Committee was fully aware also that the adoption by the Maryland Medical and Chirurgical Faculty of its report of April 1944, and the subsequent incorporation of its recommendations in the Acts of 1945 could not and would not guarantee at once the birth of a full grown, robust medical care program in the counties of Maryland. The situation existing at the inauguration of the service and still existing today is that described by Dr. Riley in the concluding paragraph of his article Medical Care in Maryland:

> "The program is a new venture in public health and one that may be accompanied by errors. It is believed, however, that vigilance to detect these mistakes and willingness to correct them will help to insure its success. Above all, needs of groups intended to benefit from the medical services must be kept in the foreground, for the entire medical care program has been established for the sole purpose of serving these sections of our population."

It is pertinent at this juncture to point out that the delegation of administrative responsibility for the medical care program to local health units was made possible by the pattern of organization of county health departments which has been developed during the last two decades. Each of the twenty-three counties has a health department with at least a minimum staff consisting of a physician who is the health officer, two or more public health nurses and clerical personnel, all serving on a full time basis. In the larger counties the minimum staff is supplemented by assistant health officers, dentists, additional nurses and nursing supervisors, medical social workers, sanitarians, and other auxiliary personnel. The administrative head acts both as County Health Officer and Deputy State Health Officer. He is appointed by the County Board of Health but his appointment must be approved by the State Board of Health. As County Health Officer, he is responsible to the Director of the State Department of Health. The county health department is financed jointly by State and local funds. The local administration of the medical care program is one of the responsibilities of the health officer in his capacity as Deputy State Health Officer.

Health officers in charge of their administrative units have the responsibility of developing an efficient medical care program and at the same time improving, by strengthening and enlargement, their already existing preventive program. Both programs are dynamic and, with increasing medical knowledge, must grow in order to be vigorous. It should be made clear that what is ordinarily termed the preventive program has by no means reached a state of perfection. The health officers fully realize this situation. They know that their major task is to make the preventive program better and to reach more people as speedily as the public opinion they influence permits. They know, too, that the medical care program must receive the same treatment.

The medical care program should stimulate the preventive program to develop more rapidly and in a healthier way and the preventive program should be of great assistance to the curative. But the fact remains that both preventive and curative techniques and practices must be improved and new areas must at the same time be developed if there is to be full integration of preventive and curative services and an enlarged and more efficient public health service by the health department. This improvement of total service and all of its dependent categories continues to be the constant preoccupation of every health officer.

The absorption of new functions within the department is not new to the health officers in Maryland. As an excellent example the child hygiene program was assimilated not many years ago. In a short time child hygiene became an integral part of the program of every local health department. Medical care will follow the same course, becoming more and more part and parcel of the whole program, and for the same significant reasons, chief among which are the productive efforts of enthusiastic health officers and their well directed and properly staffed health departments.

The medical care program in the counties of Maryland is unique. Since its inauguration in 1945, it has made remarkable strides and within this relatively short period of time has achieved many of the objectives visualized before it was actually begun. The task of organizing this new and all-inclusive service under the several county health departments has been one of first magnitude. Its accomplishments have been due almost wholly to the unusual and sustained interest of the county health officers under the guidance of the Bureau of Medical Services. However, it becomes evident, as the program emerges from its period of organization, that many of the county health departments look upon the medical care program as an activity

quite separate and apart from the preventive services. This is not always the result of lack of interest or enthusiasm. During the period of organization it has been necessary to place first emphasis on the development of the administrative machinery required for the operation of this new health department responsibility. As a consequence, the importance of coordinating the medical care program with preventive services has sometimes been neglected. It is a timely and pertinent observation of those who have recently studied the medical care program in the counties of Maryland that unless the health departments can make all of the proven preventive services available to clients of the medical care program, there can be little justification of health department administration of medical care.

On May 22, 1947, a little more than two years after Governor Herbert R. O'Conor signed the bill which had been passed by the State Legislature, and thus made legal the provision of medical care in the counties of Maryland, Dr. Robert H. Riley, Director of the Maryland State Department of Health, appointed a committee of four health officers and two representatives of the central office to study, discuss and make recommendations concerning the ways and means for establishing policies to promote closer coordination between the preventive and curative services. The charge, in terms of the responsibilities of the committee, is given as an insert in the first pages of this report (pages 4 and 5).

As a result of detailed study on the part of individual committee members, of conferences covering several months and of a meeting of health officers and bureau chiefs held on January 22, 1948, the following statement of suggested policies was prepared. Its purpose is to create as soon as possible a maximum of interest on the part of every health officer and health department staff member in integrating every preventive service

now available with the curative services to be conducted in the county.

THE COUNTY ADVISORY COMMITTEE ON MEDICAL CARE

A far-seeing decision was reached in the early days of the organization of the State-wide Council on Medical Care whose establishment was provided for in one of the sections of the Medical Care Law. The Council recommended the creation in each county of a County Advisory Committee on Medical Care.

The membership of this Advisory Committee as originally suggested included three physicians nominated by the County Medical Society; one representative of the County or District dental society and one pharmacist chosen by the Maryland Pharmaceutical Association. The Executive Secretary of the County Welfare Board, the Chairman of the Board of County Commissioners or his delegate and the county health officer were to serve ex officio. The health officer was to serve as Chairman. The Council further recommended that additional members named by the health officer should be chosen from minority racial groups, the Department of Education, the local hospitals and existing special lay health organizations.

The health officers of the several counties at once organized Committees on Medical Care in accordance with recommendations of the Council, but later observation has shown that many of the county committees are now meeting with only a fair degree of regularity. It should be pointed out here that the Council laid particular emphasis upon the importance of this local advisory group and requested that every county committee should, when it was completed, submit to the Bureau of Medical Services a program of its proposed method of operation. Only after review and approval of this program by the bureau could the supply of services be begun in any county.

It was soon evident from the experience of many counties that

the health officer could enhance the close working relationship between the practitioners of medicine and the health department by the establishment and continuation of an active committee on medical care. Such a committee demonstrates its value by advising the health officer in regard to local situations in the county so that he may more intelligently and effectively plan and carry out a program which is adjusted to the needs of his particular county.

The effective functioning of an advisory committee on medical care or other similar counselling group as a useful administrative instrument depends largely upon the ingenuity of the individual health officer in bringing together the key people in the official agencies and in the important professional and lay groups. Leadership is a quality which can be acquired and developed, but it can be exercised only by care and continuous effort. The health officers of the counties of Maryland have so far shown good leadership in their counties, but constant effort needs to be made by each health officer to continue and develop it. A well organized advisory committee is important evidence of successful leadership on the part of a health officer.

It is the concensus of the Committee on Coordination that the importance of the County Committee on Medical Care can hardly be overestimated. The frequency of meetings may vary with the needs and conditions in individual counties, but there should never be less than four meetings each year. A regular monthly meeting is desirable, but where the committee is large, subcommittee meetings may be held monthly or at even shorter intervals and the meetings of the whole committee may be held less frequently. Some health officers may wish to enlarge the membership of the committees, as has recently been recommended by the State Council, and to expand the program of the committee to a consideration of any of the functions of the health depart-

ment, whether preventive or curative.

THE COUNTY HEALTH DEPARTMENT AND THE PRIVATE PHYSICIANS

At the beginning of the medical care program each health officer presented the proposed plan to his county medical society for its endorsement. It is thus both wise and just for the health officer to make periodic reports to the society of the progress of the various phases of the complete program of the health department, preventive or curative. The frequency of these reports must, of course, depend upon the judgment of the health officer.

New Physicians. A personal interview between the health officer and every new physician who establishes a practice in the county is a valuable way of promoting a close working relationship between these practitioners and the health department. This conference may well include a thorough review of all health department activities which have a bearing on the practice of medicine. It should cover such matters as the reporting of cases of communicable disease and the various clinic services provided by the department, as well as the services available through public health nurses and the department laboratory. The medical care program can be fully explained and the physician supplied with all the forms needed for participation in the program at this interview. Such a conference will do much to strengthen the working relationships between the medical profession and the health department.

Established Practitioners. In some counties the health officer may be able periodically to visit all the private physicians practicing in his county. Where this is possible, the health officer is able to keep the practitioner fully informed regarding his working connection with the services of the health department.

Visits of Public Health Nurses to Private Physicians. Another valuable aid in securing the fullest cooperation between the health department and the private practitioners of medicine is a regular visit by the public health nurse to the private physicians in her district. The purpose of the visit should be to explain to the physician the ways in which she may be helpful in his work with his own patients. Such visits by the public health nurse are of value only when the health officer has already established a friendly cooperative relationship with the particular physician to be visited.

Public Health Education. The Committee on the Coordination of Preventive and Curative Services recognizes the need for a more effective program of public health education and of better public relations particularly with the professional groups primarily concerned. A striking example of poor practice in such matters is the large number of mimeographed sheets now sent in unsealed envelopes to physicians. Any public relations expert will testify to the complete ineffectiveness of this and of certain other methods now in use. These should at once be changed if public health information is to be gotten to the private physician in such a way as to produce effective action.

This is a subject beyond the charge to this committee and it is suggested that a separate group be appointed to study the problem.

PATIENT MASTER INDEX FILE OF PREVENTIVE AND CURATIVE SERVICES

At the present time each county health department maintains a separate file for each specialized program. A single patient or family may have records in as many as four or five of these files, but the files are not crossed-indexed or coordinated. For example, when a patient comes to a maternity hygiene clinic there is no simple way of determining whether

or not this patient has also received service from the tuberculosis program or the medical care or any other department program. In order to provide a simple means for assembling all the pertinent data concerning a particular patient, it is recommended by this committee that a master index file be maintained in each health department. This file would contain a separate card for each individual served by any program, preventive or curative, of the health department.

The size and shape of cards used in such a master index file should be uniform for all counties, and the card should contain all the data necessary to identify any individual known to be a recipient of service from the health department. This should include the name, color, sex, date of birth, and, to prevent confusion of patients with the same name, the name of the head of the family. There would be entered on each card the type of clinical record already on file in the health department and the place in which it is to be found. The type and location of records may be indicated by abbreviations or coded numbers, depending upon the wishes of the individual health officer. Information may also be recorded as to whether the record is active or inactive. It is most important that the individual cards be filed in alphabetical order by surname and be readily available, completely summarized and easy to use. An illustration of an index card of the type the Committee on Coordination has in mind will be found in the Appendix, Page i.

The maintenance of a master index file in each county health department should be made the duty of one clerk who will give to it as much time as may be necessary. This clerk is charged with the responsibility for making all entries and keeping the file current and in satisfactory order. Provision must necessarily be made that all information on new and on closed cases be reported at once to the clerk in charge of the file by field and

clinic workers. The specific method of carrying this out in the several counties will, of course, vary somewhat according to local conditions.

PERIODIC REVIEW OF MEDICAL CARE CASE SUMMARY RECORDS

The MEDICAL CARE CASE SUMMARY RECORD (MS-8) contains information which, if carefully reviewed by the health officer, gives valuable aid in determining the amount, kind and quality of care that is being given. A periodic review of these records is perhaps the best means of becoming familiar with the over-all operation of the program in a county and of the individuals receiving care as well.

These summary sheets are made up from the MEDICAL REPORTS OF SERVICES RENDERED (MS-4) and DENTAL REPORTS OF SERVICES RENDERED (MS-5), which are the monthly statements of the services rendered by individual physicians or dentists. This service record was designed to give the maximum possible amount of useful information without being unduly burdensome to physicians. It may be necessary at some time in the future to revise both these forms so that they will furnish more complete information regarding the examinations made as well as the diagnosis and treatment, but for the time being they appear to be as adequate as the situation demands.

The medical care clerk should be instructed to select from the files for review by the health officer any MEDICAL CARE CASE SUMMARY RECORDS (MS-8) that present unusual features or problems. The health officer should also be acquainted with all those cases that have incurred unusual expense to the program, as well as those who have sought the service of many physicians, or those who have had multiple diagnoses. He should also know of cases that present unusual diagnoses or whose diagnosis does not appear to be consistent with the service rendered, for example, a case of severe disease with few visits, or conversely, a disease of moderate severity with many

visits. He may wish to review the records of certain patients diagnosed as having a reportable disease, in order to discover any case that may not have been reported to the health department. He may want to review the records of cases diagnosed as cancer, heart disease, diabetes and similar conditions, particularly if he plans to establish a special program or clinic for the special service of patients with these diseases.

With these things in mind, the medical care clerk should in the course of her daily work, select from the files, for review by the health officer or his representative, groups of MEDICAL CARE CASE SUMMARY RECORDS (MS-8) on the basis of the following criteria: (1) cases costing more than $50.00 in a period of six months, excepting obstetrics and surgery, or cases costing more than $25.00 in a period of one month, with the same exceptions; (2) all cases showing use by a client of two or more physicians in any one month, unless one of the two is a specialist; (3) all cases having multiple diagnoses; (4) all cases needing special study such as reportable diseases and special conditions such as cancer, heart disease or diabetes.

The health officer may set aside a regular time for reviewing the information on the summary records which have been withdrawn by the medical care clerk on the basis of the criteria cited above. In some counties where preliminary studies have been made, experience has shown that the health officer or his representative can obtain valuable information regarding the operation of the program by such a systematic review of these records. Evidence of inadequacy of medical care or of abuse of the program by vendees or vendors may be noted. Any apparent discrepancy between the diagnosis as recorded by the physician and the amount and character of service reported as given may be recognized. The health officer may judge if the preventive measures offered by the health department have been utilized, or if hospital-

ization for acute or chronic disease is desirable. If hospitalization would afford better medical care to the patient than frequent home visits by an attending physician, that fact may be apparent from the record. It may be possible to judge if rehabilitation service would be beneficial to a particular case or to estimate the extent of any deficiency in the notification of reportable disease in a large segment of the population. Where the information concerning a case indicates that the health officer and attending physician should confer regarding the future management of a case, such a conference may be arranged.

The county advisory committee on medical care can and should play an active part in assisting the health officer in reviewing any of the summary records that present special difficulties or that cannot be handled in a routine manner. The committee can be of invaluable assistance to the health officer in difficult and puzzling cases, particularly when the health officer feels need of the advice of medical men better acquainted than himself with methods of diagnosis and treatment.

When found necessary, or advisable, the health officer should confer personally with the physician treating the patient whose records have been reviewed, and should discuss with him the findings about which question has arisen. Any action of a health officer in disposing of difficult or controversial cases should take into account the diagnostic, consultation, hospital, clinic and rehabilitation services available in his community. Each health officer should work out a method of his own for the disposition of especially difficult cases. He may, for example, after consultation with his county advisory committee, decide to form a subcommittee consisting of physician members who would sit with him individually or collectively when he confers in his own office with a particular physician who appears, from the data on

the MEDICAL CARE CASE SUMMARY RECORD (MS-8) of cases treated by him, to be incompletely informed regarding the provisions of the program or to have misinterpreted them or who seems to be abusing the service.

An attending physician should be asked to make a special review and report on cases which the health officer has found to have required continuous care over too long a period. A carefully phrased letter based on the facts of the individual case in question will usually be found better than a printed form for this purpose.

The health officer should always keep in mind that these situations are most liable of all his relations with physicians to give rise to misunderstanding and resentment. Each case should be handled with extreme care and with the utmost tact and consideration. To suggest even indirectly that the physician is neglecting the patient on the one hand, or making unnecessary visits on the other, will almost always arouse antagonism and may permanently destroy the possibility of maintaining good relations between the doctor and the health department.

CONSULTATION SERVICES

Over a period of years the specialized programs of the health department have developed a nucleus of important consultation clinics in the fields of obstetrics, pediatrics, orthopedics, otolaryngology and cardiology. This program has recently been strengthened by the establishment of cancer detection clinics and will in the near future be further enlarged by additional psychiatric clinics developed under the mental hygiene program.

Utilization of Existing Consultation Clinics. The medical care program should not establish consultation services which in any way duplicate those already in operation. Every effort should be made, however, to encourage full utilization of existing clinics by patients who are eligible

under the medical care program, as well as by patients who are eligible under other health programs. The Director of Services for Crippled Children has indicated that the consultation clinics sponsored by that program are open to patients of the medical care program. Physicians should be encouraged to refer such patients as are in need of consultation services, to the orthopedic, cardiac and hearing clinics sponsored by the crippled children's program. The availability of this service should be given full publicity.

The services of the chest clinics are also fully available to clients of the medical care program. This makes possible referral of all persons having serious chest conditions and is not limited to cases having or suspected of having tuberculosis.

The medical care program discovers many patients with complicated gynecological problems who are greatly in need of consultation service. It is to be hoped that consultation clinics in gynecology may soon be developed under the supervision of and utilizing the staff of the Bureau of Child Hygiene.

Establishment of New Consultation Clinics. The Bureau of Medical Services should endeavor to supplement existing consultation services by the establishment, as soon as is practicable, of new consultation clinics in such fields as ophthalmology, internal medicine, surgery and in any other fields in which consultation services are needed and are not now available. The medical staffs of these consultation clinics should possess the highest possible professional qualifications. They should preferably be licentiates of the appropriate specialty board or have equivalent training and experience. Wherever practicable use should be made of members of the faculties of the medical schools. Such consultation services might well be developed under the guidance of a committee representing the University of Maryland School of Medicine and The Johns Hopkins School of Medicine.

PUBLIC HEALTH NURSING VISITS TO MEDICAL CARE PATIENTS

The health department should make every effort to have a public health nurse visit each case or family as soon as possible after admission to any of its services. The visit should be designed both to determine the health needs of the patient and his family and to give any necessary nursing care. The nurse should always attempt to teach some one in the home to render as much of the necessary nursing care as possible so that too frequent nursing visits will not be required.

Before inaugurating such a nursing system, the health officer should discuss with his advisory committee the method of arranging with the attending physicians for such nursing visits. In most cases it would seem advisable for the health officer to present the matter to every eligible physician at the beginning of the program, either individually or at a county medical society meeting. This should do much to avoid misunderstanding on the part of the physicians and prevent the development of any feeling that the nurses were in any manner checking up on the attending physicians.

All cases enrolled in the medical careprogram should as far as is practicable be visited periodically by the public health nurse. Such visits will frequently bring to the attention of the nurse other persons in the family who need either preventive or curative service which might be provided by the health department.

The patient master index file can very well be used as a basis for the scheduling of nursing visits to individual cases. Those cases should be visited which have not been seen by the nurse within the period specified in the nursing policy of the department. This period will vary according to the need of individual cases and will of course be dependent upon the nursing personnel available. The actual planning of the frequency of visits will

therefore be based on the judgment of the health officer. In all visits of this nature and in all plans for the care of patients and families visited, the public health nurse should be guided by the Nursing Manual of the Maryland State Department of Health.

ROUTINE PHYSICAL EXAMINATIONS

It is evident to everyone familiar with the medical problems in the social and economic classes from which come most of the patients receiving medical care under the State program, that there exists in this group a great reservoir of unrecognized and therefore untreated disease and defect. Ideally, it would perhaps be advisable to provide a system whereby all recipients of the service would receive a complete physical examination at the time of their enrollment and at stated periods thereafter.

The economic and technical difficulties in the way of establishing such a system are however so great that it is obviously impracticable to attempt to put it into effect at this time. It is, therefore, all the more important that the facilities for diagnosis that are now available should be used to the fullest possible extent.

Two of the most valuable aids to diagnosis, an x-ray of the chest and a chemical and microscopic examination of the urine, can now be provided without difficulty through the existing facilities of local departments of health. It would therefore seem the part of wisdom to explore the possibility of furnishing these two diagnostic services to every new case enrolled for medical care. The results of this exploratory procedure may well point the road to a practicable plan for more comprehensive examinations in the future.

CHILD HYGIENE SERVICES

Maternity. Present prenatal clinics and obstetrical consultation clinics can be enlarged and expanded and new clinics organized in areas where there is need to furnish increased care to medical care patients. As a part of this expansion the present policy of calling the attention of private physicians to the availability of these services should be continued.

As soon as possible after an application for maternity care in the medical care program is received the patient should be visited at home by a public health nurse who will determine the needs of the patient for maternity services and explain to her those available through the health department.

Infant and Preschool. Child health conferences should similarly be enlarged and new services inaugurated in areas as need arises. This need can frequently be determined on the basis of the distribution within the county of medical care patients less than six years of age. Here again, as in maternity hygiene, it is important to continue the present policy of calling the attention of the private physicians to the availability of child health conferences.

An application for pediatric service under the medical care program should wherever possible be made the occasion for an immediate home visit by a public health nurse. The purpose of the visit should be to determine the need of the patient for existing health department pediatric services, to explain to the parent the availability of these services and wherever possible to arrange for enrollment of the infant or child in a child health conference if only for immunization purposes.

School Health Services. School health services in Maryland are rendered as a joint activity of the departments of education and health and

the coordination of preventive and curative medical services for this age group is an extremely complicated matter. It is to be hoped that the joint State School Health Council will be of assistance in this matter, and it is recommended that in each county there be formed a county school health council with the health officer and the superintendent of schools serving as cochairmen. In this group the local parent-teacher association, medical society and dental society should also be represented. These councils should have regular monthly meetings if they are to provide the necessary service of coordination.

The medical care program can be of value in finding pediatric patients of school age. Automatic follow-up of all such cases should be provided through school health services to determine whether or not any school, environmental changes, special rehabilitative measures, or other action may be indicated. Each county health department should adopt the policy of calling to the attention of private physicians and of educators and parents as well, the availability of certain public health services for school-aged children. This may well be done through the medium of the county school health council. The State School Health Council stands ready at all times to assist the preventive and curative programs of the county health departments in matters relating to all phases of pediatric care for school-aged children.

DENTAL SERVICES

Factors in Dental Services. The complexities involved in rendering either preventive or curative dental services by public agencies tend to make it a major problem in public health. Among the difficulties are: (1) the almost universal prevalence of dental caries, the results of the neglect of dental caries and the recurrent character of dental diseases; (2) the inadequacies of present facilities for dental service as indicated by

dentist-population ratios; and (3) the great lack of appreciation on the part of the public of the importance of oral health, of the value of preventive dental practices and of "preventive-curative" care for the young age group.

These factors with many others indicate the necessity of approaching the solution of the problem of dental health, through either preventive or curative methods, by a concentration of effort within a limited age group which offers, by its size, a reasonable chance of complete coverage and, by its age, an opportunity for truly preventive activity.

Preventive Dental Services. By preventive dental services is meant:

1. Dental health education. Such a program should be directed toward informing the public on the importance of: (a) the dento-nutritional relationship; (b) proper mouth hygiene (cleanliness); and (c) regular examination by dentists.
2. Services based on new dental procedures. At least two new procedures may at present be accepted as proper services for health department administration. These are: (a) bacteriological diagnosis for determining individual susceptibility to dental caries; and (b) the topical application of fluoride to the teeth.

Preventive-Curative Services. Preventive-curative services are those operative procedures carried out, usually in younger children, as a means of preventing incipient and small defects from becoming gross. This activity is the one that promises the best results so far as future dental health is concerned. It is essential to the success of such a service that

it be concentrated on the completion of all the dental needs of as many individuals as possible rather than the partial completion of the needs of larger groups. Removal of sources of infection by extraction of non-savable teeth is, of course, a necessary "preventive" service. However, the eventual evaluation of a dental health program may well be based on a ratio of a large number of teeth conserved by filling as against a small number extracted.

Restorative Services. This service includes those procedures necessitated by previous failure to employ the foregoing "preventive" practices. In older age groups restorative service is based principally on the necessity for: (a) masticatory function; (b) appearance, as influencing employability; and (c) health as it is influenced by lack of functions and by appearance.

Need for Coordination. Consideration of dental health services tends to emphasize the need for a closer correlation between health departments and the dental profession. The limitations ordinarily associated with dentistry have served, unfortunately, to minimize the utilization of the profession as a bulwark of general public health activities. It seems obvious that a clearer understanding of health department activities by members of the dental profession would well serve both groups. The desirability of a closer relationship is also based on the fact that in the hands of the general practitioner of dentistry lies the ultimate solution to the problem of dental health.

LABORATORY SERVICES

Present and Future Growth of Laboratory Services. It is recognized that an active and efficient program which seeks to correlate preventive and curative services in county health departments will of necessity require progressively extending laboratory services for patients of the

medical care program who are to receive increased preventive and curative services at the hands of the local health department and the private physician. The need for laboratory service is obvious if physical examinations are to be conducted under the auspices of the county health department on patients enrolled under the medical care program.

Information to Physicians. Current information as to the services available is of inestimable value if the laboratory is to make its full contribution to the program of the health department. Recently a multilithed booklet giving concise information about specimen mailing containers available, types of specimens to be sent to the laboratory, and accurate designation of outfit in ordering has been sent by the Bureau of Bacteriology to all the registered physicians in Maryland. This is a commendable step in the direction of informing the practitioners, the chief users of the laboratory service.

Leaflets issued to private physicians by the Bureau of Bacteriology regularly at short intervals can be highly effective in raising the quality of laboratory service for the individual patient by inculcating in the minds of physicians, through information, a greater discrimination of use of particular services. These leaflets can be prepared so as to include essential information on the clinical characteristics of a particular disease, types of tests which can be made and their character, value and limitations of the various tests. Requests for such information are constantly received. It would be of great value to Maryland physicians and health officers to have such carefully prepared leaflets, one for each commonly met disease, issued to them as frequent, regular bulletins by the Bureau of Bacteriology.

PLANS FOR MORE COMPLETE UTILIZATION OF REHABILITATION SERVICES

The curative services provided by the health department can be substantially strengthened by coordination with the Vocational Rehabilitation Program of the State Department of Education. The Rehabilitation Program offers a very complete range of services to persons who have a physical disability which constitutes a vocational handicap. For such persons the Rehabilitation Program provides the following services:

1. General medical examination by the family physician.
2. Consultation and diagnostic services as indicated.
3. Physical restoration which may include surgery.
4. Certain types of medical, dental and psychiatric treatment.
5. Prosthetic appliances including artificial limbs.
6. Hearing aids.
7. Vocational training, counselling, guidance and job placement.

The services indicated above are available only to persons who offer a reasonable prospect of placement in remunerative employment. In the review of MEDICAL REPORTS OF SERVICES RENDERED (MS-4) and MEDICAL CARE CASE SUMMARY RECORDS (MS-8), the health department should keep constantly in mind the possibility of referral of suitable cases to the Rehabilitation Program.

In order to make full use of the Vocational Rehabilitation Program the following suggestions are made to county health departments:

1. Obtain a supply of descriptive literature of services available from the Vocational Rehabilitation Program, State Department of Education, Lexington Building, Baltimore 1, Maryland. This descriptive material should

be brought to the attention of the entire staff of the health department, particularly the public health nurses and the medical care clerk, who should be intimately acquainted with the services available.

2. Invite representatives of the Rehabilitation Service to discuss their program with the staff of the county health department.

3. Invite the local representative of the Vocational Rehabilitation Program to review periodically with the health officer MEDICAL CARE CASE SUMMARY RECORDS (MS-8) in order to find patients suitable for rehabilitation services.

CONCLUSIONS

Three years after its inauguration in its constituent counties the Maryland Medical Care Program shows satisfactory progress toward the absorption of functions peculiar to a medical care program into the older functions, now often referred to as the regular functions, of the county health departments. Much needs to be done to bring these preventive services into more perfect alignment with curative services as exemplified by the medical care program. The Health Officer Committee on the Coordination of Preventive and Curative Services has carefully explored all the factors which in its judgment may so far have had a bearing upon the success of this absorption. The Committee has considered as well those factors which in the future may influence the smooth and speedy establishment of a closer working relationship between the preventive and curative services in the interests of a broadened and more efficient public health service to the people of the State by the several county health departments. The general conclusion has been reached that

medical care as it has been established and applied in Maryland, is rightfully a function of the State Health Department and its component local health units. This opinion is concurred in by the deputy health officers who have participated in the thoughts and discussions of the committee and by those vitally and immediately concerned in the central office who have been consulted or have supplied material to the committee.

The major assignment of the Committee on Coordination has been the task of bringing into existence a list of ways and means for improving immediately and at long range, whenever possible, the preventive and curative services of the county health departments and for effecting as rapidly as is reasonable a complete integration of these two services. The assignment has been accepted and the task assumed by the committee and the results of its work are shown in summary form in a series of recommendations. It is with every guarded hope for the soundness and lasting practicability of these recommendations that the committee submits them.

RECOMMENDATIONS

1. The county advisory committee on medical care is, when wisely directed by the health officer, a useful instrument in enhancing close working relationships between the health department, the private physician and other key individuals in official and non-official agencies. Such a committee should meet regularly. Serious and immediate consideration should be given to enlarging the membership to include those individuals familiar with school health and general health activities.
2. Periodic reports of the progress of various phases of the complete health department program should be made by the health officer to the county medical society. The frequency and character of these reports must rest entirely with the judgment of the health officer.

3. The health officer should include in his duties a personal interview and conference with each new physician who establishes a practice in the county. This conference should include a thorough review of all health department activities.

4. An effort should be made by the health officer to establish a regular procedure for visits by the public health nurse to the private physicians in her district. This is possible only when the health officer has been able to achieve a friendly, cooperative relationship with those physicians who are designated for such visits by nurses.

5. There is evident need in the county health departments for a more effective program of public health education and of public relations particularly those directed toward professional groups. The Committee on the Coordination of Preventive and Curative Services recommends that a special committee be appointed to study this problem.

6. Each county health department should establish as soon as practicable a master index file, alphabetically arranged, of individuals receiving services, both preventive and curative, from the health department. This file should be maintained in readily usable and current condition and should form the basis for planning for the individual and the family every available service of the health department.

7. The Committee on Coordination of Preventive and Curative Services is strongly of opinion that it is a highly important and almost necessary procedure to institute and systematize a review of the data currently entered on the MEDICAL CARE CASE SUMMARY RECORD (MS-8) in each health department in order to maintain a satisfactory current knowledge of the way in which the medical care program is being carried out in the county. Review of the information on the MEDICAL CARE CASE SUMMARY RECORD (MS-8)

should be a critical one carried out routinely by the health officer or his representative.

The county advisory committee on medical care should play an active part in assisting the health officer in reviewing those MEDICAL CASE CASE SUMMARY RECORDS(MS-8) which present special difficulties and cannot be handled in a routine manner.

The attending physician should be asked to make a special review and report on cases which the health officer has found to be requiring continuous care over a period of several months. The special precautions necessary in this procedure are suggested.

8. The Bureau of Medical Services should endeavor to supplement existing consultation services by the establishment of new consultation clinics in such fields as ophthalmology, internal medicine and surgery, and in any other field in which consultation services are needed and cannot be made available through other existing services.

Physicians staffing consultation clinics should carry the highest possible professional qualifications and be licentiates of the appropriate specialty board or have equivalent training and experience. If possible, they should be members of the faculty of an approved medical school.

The consultation services might well be developed under the guidance of a committee representing the University of Maryland School of Medicine and The Johns Hopkins School of Medicine.

9. A continuing approach should be made by county health departments toward the ideal procedure of having the public health nurse visit each case or family as early as possible after admission to health department services to determine the health needs of the patient and family and to give the

necessary nursing case, but before inaugurating this service the health officer should discuss with his advisory committee on medical care the method of clearance of such visits with the patient's physician.

The public health nurse should be guided by the Nursing Manual of the Maryland State Department of Health in making visits and planning the care of the patient and family.

10. Consideration should be given to the need for providing routine physical examinations for recipients of medical care, but before attempting to develop any such program, it is believed by the committee to be essential that a careful "pilot" study be conducted in a selected area.

11. Present prenatal clinics and obstetrical consultation clinics should be enlarged, expanded and organized in new geographical areas as indicated by the demand to furnish increased care to medical care patients as well as to suitable individuals not included in the medical care program.

Wherever possible, application for maternity care in the medical care program should result in an immediate home visit by a public health nurse to determine the need of the patient for existing services and to explain to the patient the availability of these services.

Child health conferences should be enlarged and new ones inaugurated in geographical areas where the need is demonstrated. The standards of need for these conferences should be restudied in terms of distribution within the county of medical care patients less than six years of age.

Wherever possible, application for pediatric care should be made the occasion for an immediate visit by a public health nurse. The purpose of the visit should be to determine the need of the patient for existing health department pediatric services, to explain to the patient

the availability of these services and whever possible to arrange for enrollment of the infant or child in a child health conference if only for immunization purposes.

Each county health department should adopt the policy of calling to the attention not only of private physicians the availability of certain public services for school-aged children, but also of educators and parents through the medium of a county-wide school health council.

12. Vigorous efforts should be made by the health officer to bring about as soon as possible a closer coordination of the program of the health department with the individual practitioners of dentistry. Specific recommendations as to ways of improving distribution of dental health information to private dentists may be forthcoming, when and if a committee is found to study public health education and public relations among professional groups as given in Recommendation 5. above.

13. It is recommended that laboratory services be enlarged as is necessary to meet the growing demands to be placed upon it by patients actually treated clinically in the medical care program.

Steps should be taken to inform continuingly all the private physicians of the county concerning the exact nature of laboratory services which are currently available.

Leaflets should be prepared and issued by the Bureau of Bacteriology to private physicians and health departments relating the clinical features of the more common diseases with the types of tests which can be made and the character, value, interpretations and limitations of the various tests.

14. The curative services provided by the health department can be substantially strengthened by coordination with the Vocational Rehabilitation Program

of the Maryland State Department of Education. In order to make full use of the rehabilitation program, it is recommended that each county health department:

1. Obtain and bring to the attention of the entire staff of the health department, particularly the public health nurses and the medical care clerk, descriptive literature of services available from the vocational rehabilitation program.
2. Invite representatives of the rehabilitation service to discuss their program with the staff of the health department.
3. Invite the local representatives of the Vocational Rehabilitation Program to review periodically with the health officer MEDICAL CARE CASE SUMMARY RECORDS (MS-8) in order to find patients suitable for rehabilitation services.

A P P E N D I X

Name.....Doe.....Jane.....
LAST FIRST

Year of Birth.....1920..... Sex....F.....Color...W.....
Father.....James Hall..... Mother....Irene.....
Address....Pomfret.....

Type of Record	Where Filed	Date Opened	Date Closed
....A.P.....	.PHN...LP....	..12-17-43...	..9-31-44..
....Eye.....	.A.O...LP....	..10-11-46...	.....
....Med.Care....	.A.O...LP....	...7-1-47....	.12-31-47..
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OBVERSE

Name.....
LAST FIRST

Type of Record	Where Filed	Date Opened	Date Closed
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